CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Steven L. Beshear
Governor

Neville Wise
Acting Commissioner

Division of Community Alternatives
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Janie Miller
Secretary

Reina Diaz-Dempsey
Deputy Commissioner

May 2, 2011

Ms. Mary Greene
Centers for Medicare & Medicaid Services
Office of Acquisition and Grants Management
Mail Stop C2-21-15
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: Medicaid Incentives for Prevention of Chronic Diseases (MIPCD)
Funding Opportunity Number: CMS-1B1-11-001

Dear Ms. Greene:

Please find enclosed the Commonwealth of Kentucky's, Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) grant application along with related materials. By funding this proposal, the Department for Medicaid Services (DMS) will be able offer incentives in an effort to promote effective disease prevention, disease management and healthier lifestyles.

The State Medicaid agency is the lead organization for this initiative. Collaborative partnerships with Department for Public Health and the Department for Aging and Independent Living will ensure effective and efficient oversight, coordination and implementation of activities associated with this demonstration project. Establishment of an implementation team and incentive workgroup(s) will ensure continuing progress and success of this initiative.

Thank you for the opportunity to apply for this funding. Should you have any questions or require additional information, please contact Kristina Hayden. Ms. Hayden is the principal contact person for this initiative and may be reached at (502) 564-4321 ext. 2001 or via email at Kristina.Hayden@ky.gov.

Sincerely,

Neville Wise
Acting Commissioner

CABINET FOR HEALTH AND FAMILY SERVICES
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Steven L. Beshear
Governor

Janie Miller
Secretary

April 29, 2011

Mr. Neville Wise, Acting Commissioner
Cabinet for Health and Family Services
Department for Medicaid Services
275 East Main Street, 6W-A
Frankfort, KY 40621

Dear Mr. Wise:

The Department for Aging and Independent Living (DAIL) is pleased to support the Department for Medicaid Services (DMS) grant application for the Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) program.

The DAIL and the DMS have been fortunate to work closely on many projects and the award of the MIPCD funding would further expand this affiliation. The partnership between the agencies for the provision of incentivizing Medicaid recipients to participate in evidence based programming provided by DAIL or the Kentucky Department for Public Health will do nothing but benefit the people of the Commonwealth. Further, this collaborative opportunity reinforces the alliance between DAIL and DMS – a partnership critical to the aging and disabled population of Kentucky.

We look forward to working with DMS on this initiative and solidifying our long-term partnership. On behalf of the Department for Aging and Independent Living, I offer our full support and backing of this much needed program.

Sincerely,

Deborah S. Anderson
Commissioner

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR PUBLIC HEALTH

Steven L. Beshear
Governor

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Janie Miller
Secretary

April 29, 2011

Neville Wise
Acting Commissioner
Department for Medicaid Services
275 East Main Street, 6WA
Frankfort, Kentucky 40621

Dear Mr. Wise:

As Commissioner of the Kentucky Department for Public Health, I am writing to voice my endorsement of the Medicaid Incentives for Prevention of Chronic Diseases grant submission. This Department is one of several within the Kentucky Cabinet for Health and Family Services that is responsible for most of the state's human services and health care programs. Along with the Department for Public Health, these include The Department for Medicaid Services, The Department for Community Based Services, and The Department for Aging and Independent Living.

The Department for Public Health (DPH) has had a long and productive relationship with both the Department for Medicaid Services and the Department for Aging and Independent Living. Our three Departments have a strong history of working together to improve the management of diabetes through the DPH Diabetes Centers for Excellence Disease Management Program and our Diabetes Self Management Education classes, increasing smoking cessation via the Kentucky Quit-line and Cooper/Clayton smoking cessation groups, and improving chronic disease management via the Stanford Chronic Disease Self Management Program. These existing programs will be strengthened by the joint work proposed in this grant, particularly the opportunities to incentivize participation in the programs and to strengthen existing evaluation efforts. I can assure you that DPH staff will continue to be integrally involved in the planning, implementation, functioning and evaluation of these activities should this proposal be funded.

Sincerely,

William D. Hacker, MD, FAAP, CPE
Commissioner

Project Abstract and Profile

The Commonwealth of Kentucky, Department for Medicaid Services' (DMS) Incentives for Prevention of Chronic Diseases (MIPCD) proposal contains multiple goals and objectives aimed to increase participation and education for Medicaid members regarding prevention and management of chronic diseases. Through collaborative partnerships with the Department for Public Health and the Department for Aging and Independent Living, it is DMS' goal to identify and eliminate barriers to established disease prevention and management programs and increase participation through incentive plans. The Commonwealth of Kentucky has identified various options for incentives. These options include: debit cards for Medicaid co-pays, specific over-the-counter medication not currently covered under the State Plan, produce at the local Farmer's Market or other major retail stores, or gasoline; vouchers for dental work or eyeglasses not currently available through the State Plan; and, enrollment in a local Weight Watchers program. It is the intention of DMS, within the first six (6) months of award, to establish a workgroup of members and providers to determine the final incentive package and any appropriate tiers.

The Department for Medicaid Services is seeking funding through the Medicaid Incentives for Prevention of Chronic Diseases program for a total of $10,000,000.00. This award and demonstration would operate for a minimum of three (3) years.

Commonwealth of Kentucky

Medicaid Incentives for Prevention of Chronic Diseases Demonstration

Application Narrative

Organization and Administration

Currently, the Department for Medicaid Services (DMS) is in the midst of the Request for Proposals (RFP) process to contract with qualified Managed Care Organization (MCO's) throughout the state in an effort to establish risk-based, capitated contract(s) to provide and manage the health care services for members enrolled in the Medicaid program. The RFP issued April 7, 2011 requires that respondents provide comprehensive care management services, including Disease and Case Management to promote coordination and continuity of the health services through the healthcare delivery system. Efforts will be focused on increasing access and utilization of preventive health services and measuring outcomes. Specific goals established in the RFP include, but are not limited to: measurably improve healthcare outcomes for members with diabetes and cardio vascular disease; improve care coordination especially for high cost individuals with chronic illness; and, promote wellness and healthy lifestyle.

Upon award, DMS will coordinate the incentive plans with the MCO(s) and the collaborative partnerships established with the Department for Public Health (DPH) and the Department for Aging and Independent Living (DAIL). The State Plan includes the provision of chronic disease prevention through DPH which includes Medical Nutrition Therapy (MNT) and Comprehensive Diabetes Self-Management Group Classes (DSME). The State Plan also includes a statewide tobacco cessation program. In

addition to the current preventative programs available through the State Plan, DAIL in partnership with the Area on Agencies on Aging and Independent Living (AAAIL's) offers the Stanford Chronic Disease Self Management Program (CDSMP) in four (4) regions (serving thirty-seven counties) throughout the Commonwealth. It is DMS' goal to increase Medicaid member participation in these programs through a tiered-incentive program. Additionally, DAIL plans to expand the CDSMP to other areas of the state in fiscal year 2012.

DMS will collaborate with the selected MCO(s), DPH and DAIL to detail the administrative functions of each agency and will specify those functions in the Operational Protocol. It is anticipated each agency will be required to submit data to DMS or the MCO(s) on a quarterly basis for ongoing assessment and monitoring of the implementation, utilization and outcome of the program.

Program Targeting

The MIPCD demonstration program will target the following prevention goals: tobacco cessation, reduction of cholesterol levels, lowering blood pressure and prevention of the onset of diabetes or improvement of the management of the disease.

According to the Centers for Disease Control and Prevention (2010), "In Kentucky, 25.2% of the adult population (aged 18+ years) – over 822,000 individuals- are current cigarette smokers....Kentucky ranks 49th among the states." This same data shows that the smoking rate among low income Kentuckians is as high as 44%. Applying a slightly more conservative rate of 40% to the Kentucky Medicaid enrolled population suggests that as many as 146,600 are current smokers. Kentucky has the highest lung cancer mortality (77.2/100,000) and incidence rates (99.5/100,000) in the

nation, and ranks 3rd highest for mortality due to Chronic Lower Respiratory Diseases (60.2/100,000).

"*Best Practices* estimates 8% of current smokers could access quitlines each year. In Kentucky, 2.3% of smokers called their quitline." (CDC, 2010) DMS in collaboration with DPH and DAIL would use incentives to increase awareness and participation in available tobacco cessation programs within the Medicaid State Plan and other community resources. These resources include the State Plan tobacco cessation program which was mandated (Kentucky Revised Statutes 205.560(1)(j)) and the state match funded (2010-2011 biennium budget) by the Kentucky legislature; the Cooper/Clayton Method which is offered to citizens throughout the Commonwealth at no cost; Kentucky's Tobacco Quit Line which is administered by DMS' collaborating partner, DPH, and is available to all citizens of the Commonwealth at no cost; and, the Freedom from Smoking® Online program which has a free basic membership and a low-cost premium membership. A Medicaid member's documented participation in these programs or combination of programs would be the established goal of a tiered incentive program. Smoking cessation will be targeted statewide through referrals to the state tobacco quitline and participation in group classes at local health departments utilizing the Cooper/Clayton Method to stop smoking.

In the past decade, the percent of Kentuckians who reported that they had been told that they have diabetes has nearly doubled from 6.4% in 1999 to 11.4% in 2009. Applied to the adult population of Kentucky, this means that 378,000 Kentucky adults have now been diagnosed with diabetes. As of 2009, Kentucky has the 4th highest rate

of diabetes in the nation. At the current rate of increase, the projected rate of diabetes in Kentucky 2015 will exceed 405,000.

As of 2007 the percentage of Kentuckians with a diagnosis of high blood cholesterol (HBC) was 39% (CDC, 2008) "HBC is one of the major modifiable risk factors for heart disease and stroke. One approach to reducing blood cholesterol levels has been to increase public awareness and reinforce educational messages about the risks of HBC (5,6,9). Cholesterol levels can be reduced through dietary changes (e.g., reduced intake of saturated fats and dietary cholesterol), increased physical activity, and drug treatment (7)." (CDC, 2005) Incentives will be utilized to increase active Medicaid member participation in the Chronic Disease Self Management Program (CDSMP) administered by DAIL and/or Medical Nutrition Therapy (MNT) which is administered by DPH.

Based on the most recent data from the Centers for Disease Control and Prevention, within the Commonwealth of Kentucky reported that of 100,000 deaths 220.71 were attributable to heart disease, the 10th highest among the states, 47.99 were attributable to stroke, the 13th highest among the states and 24.11 were attributable to diabetes, 20th among the states (World Life Expectancy, retrieved April 27, 2010). High blood pressure, high blood cholesterol, tobacco disorders and obesity are all contributing factors to each of these chronic diseases. Incentivizing prevention and management programs may increase Medicaid member participation leading to healthier lifestyles and proper chronic disease management.

The high prevalence rate of the aforementioned chronic diseases provides the rationale for the goals, population and statewide geographical location of the demonstration.

Comprehensive and Evidence-based

The proposed incentives will be presented to a workgroup(s), comprised of Medicaid members and providers. This workgroup(s) will select the incentives associated with each program in the MIPCD demonstration. The workgroup will determine the amount and tiering for each of the programs from the following options: debit cards for Medicaid co-pays; specific over-the-counter medication not currently covered under the State Plan; produce at the local Farmer's Market or other major retail stores; gasoline; vouchers for dental work or eyeglasses not currently available through the State Plan; and/or, enrollment in a local Weight Watchers program. Any additional incentives identified by the workgroup will also be considered.

The Stanford Chronic Disease Self Management Program (CDSMP) is an evidence based program that empowers individuals diagnosed with chronic disease to take an active role in managing their conditions. Paid or volunteer lay leaders conduct workshops that are 2 ½ hours and are presented once a week for six weeks. These lay leaders must successfully complete an intensive four day training to learn the necessary skills to teach the CDSMP classes. The classes focus on the following topics:

- Techniques to deal with problems such as frustration, fatigue, pain and isolation;
- Appropriate exercise for maintaining and improving strength, flexibility and endurance;
- Appropriate use of medications;

- Communicating effectively with family, friends and health professionals;
- Nutrition; and,
- Effective evaluation of new treatments.

There is no cost for CDSMP classes and all materials are provided by the workshop leaders. While the Commonwealth of Kentucky and DAIL are currently focusing their efforts in four (4) regions throughout the state, other lay leaders are located across the state that have successfully completed their training. DAIL also plans to provide opportunities for additional AAAIL regions to be trained during fiscal year 2012. In addition, CDSMP classes are offered via several local health departments. To date, 214 individuals have enrolled in a CDSMP class with 155 successfully completing the program. Anyone may attend and participate in a workshop but the information is geared specifically for those with chronic condition or their caregiver. This program is in its infancy stage, beginning in the fall of 2010. It is expected increased outreach will be occurring in future years. This demonstration program will focus on incentivizing those with high blood pressure, hypercholesterolemia or diabetes to enroll in and complete CDSMP classes.

The CDSMP will not conflict with existing programs or treatment. It is designed to enhance regular treatment and disease-specific education such as "Better Breathers", cardiac rehabilitation or diabetes instruction. Additionally, there are many individuals with multiple chronic conditions and this program is especially helpful as it provides them the skills to coordinate all aspects of their health as well as stress the importance of daily activity.

When compared with individuals who did not participate, an individual who participated in the CDSMP demonstrated significant improvements in exercise, cognitive symptom management, communication with healthcare professionals, self-reported general health, health distress, fatigue, disability and social/role activities. The length of hospital stay was shorter; as well as a trend toward fewer outpatient visits and hospitalizations were discovered with CDSMP participants. Based on this data, a cost to savings ratio of approximately 1:4 can be expected.

The Cooper/Clayton Method to Stop Smoking "is a safe and effective way to help people stay smoke-free for the rest of their lives. The Cooper/Clayton Method is a comprehensive behavioral smoking cessation program. It was started over 25 years ago by two faculty members at the University of Kentucky....This highly successful program is science based utilizing proven methods, which include education, skills training and social support....Participants in the Cooper/Clayton Method to Stop Smoking utilize nicotine replacement products such as the nicotine gum, nicotine lozenge, or nicotine patch...Working with The Kentucky Cancer Program and the Kentucky Department for Public Health, local health departments and numerous community partners, ongoing classes are currently conducted across the state. Most of the classes are available to Kentuckians free, except for the cost of the nicotine replacement products and the participant booklet." (stopsmoking4ever.org, retrieved April 28, 2011) The program is available in both self-help and support group versions.

Kentucky's Tobacco Quitline, 1-800-QUIT NOW, offers free one-on-one proactive counseling for tobacco users who are ready to quit using tobacco products. Services are available to Kentuckians who want to stop smoking as well as individuals concerned

about a family or friend's tobacco use. The quitline is staffed from 8:00 a.m. to 1:00 a.m. (EST) Monday through Sunday. Twenty-four hour voice mail and recorded QuitFacts are available for individuals who call after hours. An individual calling the quitline will receive free support and advice from an experienced quit specialist, a personalized quit program with self-help materials, and the latest information about the medications that can assist with cessation. All services are available in English and Spanish and translation services for other languages are available free of charge. Quitlines remove barriers that often exist with face-to-face programs such as: the need for transportation, the need for childcare services, geographic limitations associated with services, and cost. "Studies indicate that smokers are more likely to use a telephone-based cessation services than they are a face-to-face program....Quitliens also offer important advantages from a health education/program perspective. Quitlines function based on a centralized system of operation and promotion, allowing for:

- Economies of scale, where financial and staffing resources can be utilized more efficiently.
- Standardized protocols and training for all cessation/counseling activities.
- Routine monitoring of counseling for quality assurance and continuity of services.
- Easier collection and evaluation of data.
- Ease of marketing and promotion, as only one campaign is necessary, though it may be (or need to be) large scale." (Society for Public Health Education, 2005).

The Freedom from Smoking® program was designed by the American Lung Association, the American Thoracic Society, and Congress of Lung Association Staff and introduced in 1980 with the Freedom from Smoking® Online program introduced in

1996. (ffsonline.org, retrieved April 28, 2011) "The project was designed using a three-stage methodology. The first stage was a thorough assessment of existing smoking cessation programs and the research literature. In the second stage, three criteria were established for designing a new American Lung Association smoking cessation program: medically and ethically sound, cost-effective, and evidence-based and able to be replicated. In the final stage, the program was thoroughly tested according to stringent research standards. Three different approaches – media, self-help and clinic – were chosen for development and testing to reach different segments of the population. These three approaches represented a continuum from less to more contact with the individuals who smoke." (ffsonline.org, retrieved April 28, 2011)

The current State Plan provides chronic disease services through the Department for Public Health or its subcontractors. Medical nutrition therapy (MNT) is a service provided by the local public health departments designed to improve quality of life while maximizing limited health care system resources. Nutrition is a major element of life and plays a vital role in growth and development. Medical nutrition therapy has several major components:

- Provided by registered dietitian/licensed dietitian or certified nutritionist;
- Includes current assessment of nutritional status;
- Includes an individualized diet and activity plan that takes into consideration an individual's personal preferences, the influence of medications, current health and family health history, appropriate types of physical activity and any eating problems;

- Supports the healing process or assists in preventing further complications or future illnesses.

The registered dietitians/licensed dietitians who design nutrition plans have more than five years of training in nutrition and nutritional science. These professionals are members of the health care team advising doctors and nurses on specific nutrition care plan for patients. Medial nutrition therapy has been shown to provide treatment that result in cost savings for the health care system. For example, with MNT as a treatment component, people with Type 2 diabetes have discontinued or decreased oral medication with a diet and exercise plan. In a 10 year study of Type I diabetes through the Diabetes Control and Complications Trial, optimal blood glucose control reduced the risk of complications by 60 percent. A Massachusetts study, which included MNT for hypercholesterolemia, demonstrated a cost savings of $1,300 per patient per year. A study in Maine outlined a therapy using MNT for hypertension that decreased the dosage of medication and provided estimated 5 year cost savings of more than $900. (chfs.ky.gov/dph, retrieved April 28, 2011) In 104 out of 120 counties, Kentucky's local public health departments can provide MNT for individuals with or without insurance. MNT is a recommended service in accepted diabetes standards of care published by the American Diabetes Association (ADA).

Comprehensive Diabetes Self Management (DSME) group classes are available to Kentuckians through the public health departments. These classes are a component of the Kentucky Diabetes Prevention and Control Program which is a public health initiative consisting of a network of state, regional and local health professionals whose mission is to reduce new cases of diabetes as well as the sickness, disability and death

associated with diabetes and its complications. (chfs.ky.gov/dph) Diabetes is controllable through proper medical care, good nutrition, modest physical activity and self-management education. Nutrition education and increased physical activity can decrease the risk of developing diabetes by nearly 60 percent. The DSME classes educate individuals regarding appropriate lifestyle changes and provide the self-management skills necessary to reduce the complications or prevent onset of the disease. There is no fee for these classes. The DSME classes follow a curriculum developed by the Kentucky Diabetes Prevention and Control Program funded in part by the Centers for Disease Prevention and Control. The curriculum is updated annually to ensure they follow the standards set by the ADA and required training is provided to ensure that those offering the classes are properly prepared. Class instructors are Registered Nurses or Registered Dieticians and many are ADA Certified Diabetes Educators (CDE's). Those who are CDE's are mentored by CDE's. MNT services are included under the current State Plan.

The Department for Public Health also administers the Diabetes Disease Management/Care Coordination services through six district health departments that offer the Diabetes Centers of Excellence (DCOE). "The DCOE project is comprised of six distinct components, each of which is required to ensure the best opportunity for a successful program including: outreach, care coordination and tracking, patient self-management education/behavior change support, communication with the primary care provider, documentation and data collection, and health systems changes." (Wheeldon, November 29, 2006) Once an individual is enrolled in the DCOE program, a care coordinator will be assigned. This care coordinator educates the participant in "areas

such as symptom identification and management; self-monitoring; avoidance of triggers of clinical worsening; reduction of emotional distress; appropriate activity level; compliance with medications, diet and medical follow-up; appropriate use of emergency and primary care physician's office care and ways of interacting with physicians. Care coordination and tracking will consist of identifying target populations, inviting patients into the program using a active approach performing patient assessments, creating a plan of care and making referrals to appropriate resources and providers." The Diabetes Disease/Case Management Program is operated by DPH through the local health departments and is available in 30 rural counties. Funding for this program is provided through the general fund as appropriated by the Kentucky General Assembly. This funding streamed is designed to assist Kentucky Medicaid members with diabetes; therefore there are no fees to the Medicaid program or the members.

The Medicaid covered smoking cessation services may be provided by an enrolled physician, a physician assistant, an advanced practice registered nurse or qualified professional employed by a local health department. The smoking cessation services include a face-to-face tobacco cessation assessment performed by a qualified provider. This assessment includes a history of the tobacco use, medical and psychosocial history, review of coping skills, and barriers to quitting. At the time of assessment, the provider and member shall complete a Tobacco Cessation Referral Form. This form will indicate the choice of cessation program and the member's intent to quit using tobacco. The provider may prescribe a medically necessary tobacco cessation medication for the member. These medications may include over-the-counter products. All FDA-approved medications are covered for two 90-day treatment regimens a year. An initial one month

supply of the medication and up to two refills may be covered under this program. Prior to each refill, the member must contact DMS and confirm their intention to continue in the cessation program. Upon DMS request, the member and/or provider shall provide information regarding success or failure as a result of receiving the cessation services. To date, 555 Medicaid members have entered the smoking cessation program since its inception in 2010. Of the 301 who started the program in 2010, 223 contacted DMS for the first refill and 91 contacted DMS for the second refill. So far, 254 Medicaid members have begun the program since January 1, 2011. Of those starting the program this year, 177 have contacted DMS for the first refill and 48 have contacted DMS for a second refill. Since the program is relatively new, the true quit statistics have not yet been collected and analyzed.

Promotion and Outreach

In the efforts to secure an MCO(s) for providing and managing the health care services for Medicaid members, the issued RFP requires the MCO(s) to have programs and processes in place to address the preventive and chronic healthcare needs of the population. Further, the MCO(s) shall conduct initial health screening questionnaires for all new Medicaid members, to assess members who have not been enrolled in the prior twelve month period within 90 days of enrollment. This assessment information shall include demographic information, current health and behavioral health status to determine the member's need for care management, disease management, behavioral health service and/or any other health or community services. The MCO(s) is required to utilize appropriate health care professionals in the assessment process. Member shall be offered assistance in arranging an initial visit to their primary care physician for

a baseline medical assessment and other preventative services, including an assessment or screening of the member's potential risk, if any, for specific diseases or conditions.

Data collected by the MCO(s) during these risk assessments will be utilized to identify individuals who may benefit from participation in the prevention/maintenance programs included in the MIPCD demonstration. Once these members are identified, correspondence outlining the program benefits, incentives, contact information and enrollment will be mailed directly to them. The MCO(s) will educate the appropriate providers to encourage member referrals to these programs. Detailed information regarding these programs and the corresponding incentives will also be published on the websites maintained by DMS, MCO(s), DPH and DAIL. Published material will be developed and disseminated by each of the partners to appropriate target populations. Further promotion and outreach will be a collaborative approach between DPH, DAIL, MCO(s) and DMS in an effort to achieve maximum Medicaid member participation.

Participant Recruitment and Enrollment

Participant recruitment and enrollment shall be an open system. A Medicaid member can be recruited and begin the enrollment process at various agencies. Any Medicaid enrolled provider or other stakeholder may refer a member to the local health department or Area Agency on Aging and Independent Living (AAAIL) to begin enrollment in the programs (the one exception is the State Plan smoking cessation program). The local health departments and AAIL shall enroll the member into the appropriate program and forward the information to DMS/MCO(s) who will update the

Medicaid Management Information System to reflect the member's participation. The programs incentivized through the MIPCD demonstration are currently available to the public (most are free of charge). Coverage will not be impacted by member participation fluctuation. Promotion and outreach geared specifically toward retention will be utilized in our attempts of maintaining normal levels of participation.

Informed Consent and Guardianship

Informed consent will be obtained from the member or guardian at the time of enrollment. All program benefits, requirements and incentives will be explained and detailed documentation given to the member at the time of enrollment. Once the member or guardian completes the consent form the receiving agency will forward a copy to DMS. All completed consent forms will be retained for a period of five years after the demonstration period or the member's completion of the program, whichever is longer. A copy of a proposed consent form is contained in Appendix A along with the current referral/consent form used in the State Plan tobacco cessation program.

Stakeholder Involvement in the Proposal and Program

The Department of Public Health and Department for Aging and Independent Living were involved in the entire development of this proposal. Upon award, the Commonwealth will immediately recruit and establish an implementation team comprised of representatives from the American Heart Association, the American Diabetes Association, the American Cancer Society, at least one Area Agency on Aging and Independent Living, at least one local health department, employees from DPH, DAIL, DMS, MCO(s), and consumers from each target population. This implementation

team will meet once a month and steer the program start-up and Operational Protocol development and recommend enhancements or changes as the program continues. The incentive workgroup will report their recommendations to the implementation team.

Reporting and Evaluation

Program reporting and evaluation will build on existing capabilities, processes and system currently in place related to tobacco cessation, CDSMP, DSMT and the Kentucky Diabetes Centers of Excellence Diabetes Disease Management program. The Kentucky Department for Public Health is well versed in the use of the CDC 6 Step Framework for Program Evaluation and will provide leadership in applying this model to the grant initiatives, in consultation with the CMS evaluation contractor when this proposal is funded. At this time we plan to use a quasi-experimental design for our evaluation work in which a sample of incentive program participants is compared to a random sample of non-participants matched on multiple demographic parameters – for example, gender, age, race, months of Medicaid eligibility etc. Truncation of the population due to the changing membership of the Medicaid population (loss and addition of new members based on changes in eligibility) will be a concern, and we would welcome assistance from the CMS evaluator in how to account for that in the evaluation plan. In addressing the matter of power analysis, in our initial thinking about the evaluation, we referred to the 1987 Sage Publication How Many Subjects: Statistical Power Analysis in Research authored by Kraemer and Thiemann. The work by Kraemer and Thiemann is somewhat unique because they offer a way to allow non-statisticians to apply a single method of calculating power which is appropriate for a wide variety of different statistical tests. Based on their tables, detecting a 10%

difference between groups at 90% power will require a sample size of 426 in each group (incentivized group compared to non-participant group).

Tobacco Cessation Evaluation

Quit-Line services are available to all Kentucky residents. Evaluation of this portion of the grant will focus on comparisons between those Medicaid members who participate in the incentive program and make use of the quit-line, and a matched sample of tobacco users who do not participate in the incentive program but who also use quit-line. We estimate that 40% (146,400) of adult Kentucky Medicaid members are current smokers. The Kentucky Quit-Line system is capable of collecting the minimum data defined by the CDC Tobacco Control Program and will be the backbone for reporting data on this segment of the grant.

High Blood Pressure and High Cholesterol Evaluation

Medicaid members with high blood pressure or high cholesterol as defined using the HEDIS® methodology for population identification, will be eligible to receive incentives to participate in Medical Nutrition Therapy (currently included in the Kentucky Medicaid State Plan and provided by Nutritionists/Dieticians in the Local Health Departments) and/or to participate in Chronic Disease Self Management Program classes in areas of the state where offered.

Based on claims data for the most recent 12 month period, we estimate that 142,000 adult Kentucky Medicaid members have high blood pressure and/or high cholesterol. The evaluation will compare blood pressure and/or cholesterol control separately among the MNT participants, CDSMP participants and those who participate in both

MNT and CDSMP. In these groups we will test a null hypothesis that there is no difference in control between those who participate in the incentive program and a matched sample of Medicaid members who do not participate.

Diabetes Prevention Evaluation

A diagnosis of pre-diabetes is made when a person has a fasting blood glucose result of 100 to 125 mg/dl. Medicaid members with a diagnosis of pre-diabetes may participate in incentives to receive MNT and /or CDSMP. We estimate that 50,000 Kentucky Medicaid members may test positive for pre-diabetes. The evaluation will compare changes in BMI and increases in self reported moderate physical activity separately among the MNT participants, CDSMP participants and those who participate in both MNT and CDSMP. In these groups we will test a null hypothesis that there is no difference in BMI or self reported moderate physical activity between those who participate in the incentive program and a matched sample of Medicaid members who do not participate.

Improved Diabetes Control

Medicaid members who have been diagnosed with diabetes will be eligible to receive diabetes disease/case management services from one of the six regional Diabetes Centers of Excellence operated with state general funds by local health departments. Referrals to MNT or DSME classes is a standard part of the operation of our existing diabetes disease management program. For these patients with diabetes the goals to be evaluated with be improved glycemic control as measured by a hemoglobin A1C test, and self reported improvement in medication adherence. As part

of the Kentucky Diabetes Prevention and Control program funded by CDC, we have in place an approved evaluation plan for the Diabetes Centers of Excellence, Diabetes Disease Management program which will serve as the model for the evaluation of the activities proposed in this grant. See Appendix B for a copy of this evaluation plan.

Based on claims data, we estimate that 75,000 Kentucky Medicaid members have been diagnosed with diabetes. The evaluation will compare changes in A1C levels and increases in self reported medication compliance between those who participate in the incentive program and a matched sample of Medicaid members who do not participate.

Data for this component of the program will be documented in the DiaWEB™ software system. DiaWEB™ is a comprehensive diabetes management software system specifically developed for diabetes education programs. This web-based software is hosted on a server operated by the company Custom Data Processing, Inc., which is responsible for assuring that the software is accessible to all Regional Disease Management sites, coordinating software upgrades from the software developer (Chiron Data Systems), conducting data backups and assuring data recovery.

DiaWEB™ is an intuitively designed system which provides extensive patient management and reporting capabilities including human resource management including professional credential documentation, CEU documentation, staff productivity reporting and reporting supporting CQI and CPI processes. The system is fully HIPPA compliant with security protections.

DiaWEB has a robust reporting feature, and reports are broken into three different areas:

a. Patient management reports deliver information regarding a single patient. These reports include the complete patient record report as well as many individual reports such as notes, medications, meal plans, and letters.

b. Program Management reports to assist with staff and resource records. These reports include the staff summary, schedule and visit statistics, and insurance summary.

c. Program Outcomes reports assist in measuring the selected outcomes of the patient population. Examples of this type report are the Clinical Outcomes reports, Enrollment and Completion reports, and Goal Outcomes.

It is also possible to modify the DiaWEB system to collect data for other aspects of the interventions in this proposal, particularly CDSMP participation for those with pre-diabetes, high blood pressure or high cholesterol. The KYMMIS data warehouse will be another source of member level data in which adhoc queries will be run from claims and encounter data regarding utilization of services, financial reports or other aspects related to the MIPCD demonstration program. In addition a requirement for contracted MCO's is to collect and report to the Commonwealth, HEDIS® performance measure rates. Those measures directly related to the MIPCD demonstration program will be utilized as a component of the evaluation.

Use of these existing systems of data collection will ensure that Kentucky is able to efficiently evaluate the activities associated with this project, provide timely process

and outcome reports as required by the grant and feed data back to the CMS evaluator contracted to oversee this project. This puts Kentucky at a distinct advantage in meeting the evaluation and reporting requirements as stated in the MIPCD RFP.

Proposed Budget (Services & Administrative Costs) & Staffing Plan

The Department for Medicaid Services is responsible for the administration and management of this grant. The Department for Public Health (DPH) and Department for Aging and Independent Living (DAIL) administer the programs selected for incentivizing. All three departments are operated in the Cabinet for Health and Family Services (organization chart is included in Appendix C). The local health departments are contracted with DPH and the Area Agencies on Aging and Independent Living are contracted with DAIL.

A budget worksheet outlining the estimated expenditures is included in Appendix D. Please note, the contractual amount will include the administrative expenses associated with our collaborative partners, DPH and DAIL. It is anticipated that DMS will enter into interagency agreements with both partners.

A Project Manager will be a Medicaid Specialist within DMS and will be funded utilizing MIPCD funds. The Project Manager shall be responsible for day-to-day management of the MIPCD demonstration project. The qualifications of the Project Manager will include:

- Knowledge of and experience in designing and implementing Medicaid programs;
- Knowledge of issues for individuals with chronic diseases served by the Medicaid program;

- Experience working with consumer and community advocates and groups; and,
- Experience in Medicaid or related projects.

The Project Manager will be supervised by the Commissioner's Office and will provide staff support to the implementation team. Any needed additional staff will be hired utilizing grant funding to assist in the implementation of the MIPCD demonstration project.

A full time reporting and evaluation specialist will be hired within DPH and will be funded utilizing the MIPCD funds. This position will be responsible for collecting, compiling and analyzing the data needed for reporting and evaluation requirements associated with the DPH programs included in the MIPCD demonstration program. Additionally, MIPCD funds will be utilized to enhance and maintain the DPH reporting systems to accommodate the reporting requirements.

MIPCD funds will be utilized to enhance the current network of CDSMP classes. Currently, the classes are supported by state general funding and the addition of Medicaid members may result in waiting lists in some areas. Utilization of the grant funds to conduct these classes will allow for the expansion in the number of classes eliminating the concern. Enhancement and maintenance of DAIL reporting and evaluation systems to include the Medicaid population and MIPCD requirements will be funded through this award.

References

American Lung Association. (2011). *History of freedom from smoking®.* Retrieved April 28, 2011 from http://www.ffsonline.org/history-of-freedom-from-smoking.html

Centers for Disease Control and Prevention, Office on Smoking and Health. (2010). *Smoking & tobacco use: tobacco control state highlights 2010.* Retrieved April 27, 2011, from http://www.cdc.gov/tobacco/data_statistics/state_data/state_highlights/2010/states/kentucky/index.htm

Centers for Disease Control and Prevention. (2008). *Kentucky: Burden of chronic diseases.* Retrieved April 27, 2011, from http://www.cdc.gov/chronicdisease/states/pdf/kentucky.pdf

Centers for Disease Control and Prevention (2005, September 9). Trends in cholesterol screening and awareness of high blood cholesterol – United States, 1991-2003 [Electronic version]. *Morbidity and Mortality Weekly Report,* 54(35), 865-870.

Cooper, T., & Clayton, R. (2005-2010). The Institute for Comprehensive Behavioral Smoking Cessation, Inc. *The Cooper Clayton method to stop smoking.* Retrieved April 28, 2011 from http://www.stopsmoking4ever.org

Department for Public Health (2008, March). *Kentucky diabetes prevention and control program* (4th printing)[Brochure]. Frankfort, KY.

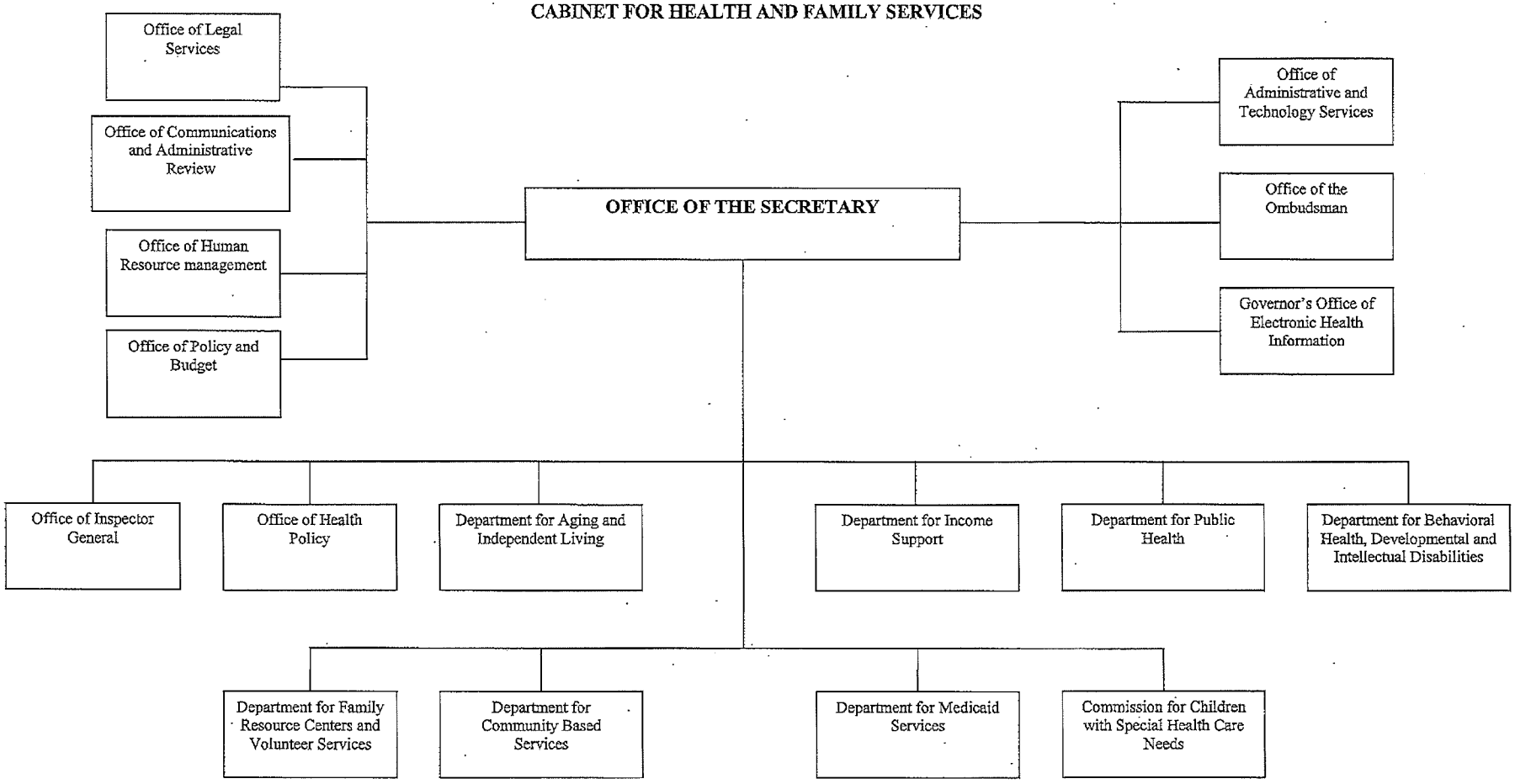
Department for Public Health (n.d.). *Medical nutrition therapy program.* Retrieved April 28, 2011 from http://chfs.ky.gov/dph/mch/ns/nutrition+services+branch.htm

Society for Public Health Education. (2005, July). *Tobacco quitlines 101: a primer for health educators.* Retrieved April 28, 2011, from http://chfs.ky.gov/NR/rdonlyres/40F8F18A-8F4B-4C7B-890C-ED2196A7D998/0/QuitLines101.pdf

Wheeldon, S. (2006, November 29). Gov. Fletcher announces new diabetes centers in area. *Commonwealth Journal.* Retrieved April 28, 2011 from http://somserset-kentucky.com/Local/x681529510/Gov-Fletcher-announces-new-diabetes-centers-in-area

World Life Expectancy. *Kentucky life expectancy live longer live better.* Retrieved April 27, 2011 from http://www.worldlifeexpectancy.com/usa/kentucky-health-profile

CABINET FOR HEALTH AND FAMILY SERVICES



Appendix D - Commonwealth of Kentucky
Budget Worksheet

Breakout of Administration Expenditures

	Salaries	Benefits	Travel	Equipment	Supplies	Contractual	Construction	Other	Total Direct	Indirect Charges	Total Direct & Indirect
MCO's	TBD	TBD	TBD	TBD	TBD	TBD	$0	$0	TBD	TBD	TBD
DPH	TBD	TBD	TBD	TBD	TBD	TBD	$0	$0	TBD	TBD	TBD
DAIL	TBD	TBD	TBD	TBD	TBD	TBD	$0	$0	TBD	TBD	TBD
DMS	$280,350	$89,700	$140,850	$22,500	$37,200	$0	$0	$0	$570,600	$18,750	$589,350
Total	$280,350	$89,700	$140,850	$22,500	$37,200	$910,650	$0	$0	$1,481,250	$18,750	$1,500,000
	18.69%	5.98%	9.39%	1.50%	2.48%	60.71%	0.00%	0.00%	98.75%	1.25%	100.00%

Program Income

Administration Expenditures at 100% Federal	$1,500,000
Incentives at 100% Federal	$8,500,000
Benefits at 30% State	$0
Total	$10,000,000

Expenditures by Quarter

	Year 1				Year 2				Year 3				
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Total
Admin Fed	$125,000	$125,000	$125,000	$125,000	$125,000	$125,000	$125,000	$125,000	$125,000	$125,000	$125,000	$125,000	$1,500,000
Federal	$708,333	$708,333	$708,333	$708,333	$708,333	$708,333	$708,333	$708,333	$708,333	$708,333	$708,333	$708,333	$8,500,000
State	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
													$10,000,000

Consent to Participate in Kentucky's Medicaid Incentives for Prevention of Chronic Diseases Demonstration Project

The purpose of this study is to learn about the experiences of participants and their caregivers before and after participating in the Medicaid Incentives for Prevention of Chronic Diseases Demonstration Project (MIPCD). Both the participant and the caregiver must both agree to participate in the program.

If you choose to participate in the MIPCD project, you will be asked to participate in community programs designed to assist you in adopting a healthier lifestyle in an effort to prevent or manage chronic disease. The study also includes the completion of surveys by the participant during and following participation in the MIPCD program. These surveys may be disseminated from the Department for Medicaid Services, Department for Aging and Independent Living, Department for Public Health or their designated contractors. All participant answers will be compiled and a report will be available that will disclose the program effectiveness which may help other people in the future. Individual responses will not be shared. No interview participants will be identified in any report or publication about this study. Your answers will be coded with identification numbers, not names, and the list linking numbers and names will be kept in a separate file. It will not cost you anything to be part of the MIPCD demonstration program.

Participation in this program and survey is completely voluntary. You may refuse to join or you may withdraw your consent to be in the program for any reason. Deciding not to be in the program or leaving the program before completion will not affect your services. Refusal to participate or discontinuing your participation at any time will involve no penalty or loss of benefits to which you are otherwise entitled.

If you have questions about this study, you may contact the Department for Medicaid Services at (502) 564-4321.

Subject's Agreement: I have read the information provided above. I have asked all the questions I have at this time. I voluntarily agree to participate in the MIPCD demonstration program.

_____ _____

Participant (Print Name) Caregiver Participant (Print Name)

_____ _____

Signature Date Signature Date

(Guardian Signature if Applicable)

Department for Medicaid Services
Tobacco Cessation Referral Form

Provider Information (to be completed by the provider)

Provider National Provider Identifier (NPI): _____

Provider Name: _____

Provider Fax #: _____ Provider Phone #: _____

Provider Email Address (if available): _____

Recipient Information (to be completed by the recipient)

Recipient ID: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female

Name: _____ Pregnant? ☐ Yes ☐ No

Prescriber: Please refer to FDA guidelines regarding the use of Chantix™ in pregnant women.

Street Address: _____

Apt/Bldg#: _____

City: _____ County: _____ Zip Code: _____

Primary Telephone#: _____ Secondary Telephone#: _____

Date of Visit: _____

Tobacco Cessation Medication Choice(s) Prescribed for the Recipient [to be completed by the provider]

☐ Nicotine replacement therapy (NRT) gum _____ ☐ NRT patch _____

☐ NRT lozenge _____ ☐ NRT inhaler _____

☐ NRT spray _____ ☐ Bupropion ☐ Varenicline

Prescription amount must be for a one-month supply with two subsequent one-month refills

Tobacco Cessation Support Program Chosen for the Recipient (to be completed by the provider)

☐ *The Cooper/Clayton Method* ☐ *Freedom from Smoking® Online*

☐ *Kentucky's Tobacco Quitline* ☐ *Chantix™*

☐ Other Program (Must be Prior Approved by the Department): _____

☐ Recipient does not require support program

☐ Support program attendance would create hardship for recipient (provider: please explain: _____

_____

_____)

IMPORTANT: If recommending a program not listed on this form, the provider MUST request approval from the Department for Medicaid Services (DMS) PRIOR to recommending the program; otherwise, the department shall not reimburse for any tobacco cessation medication prescribed in conjunction with the unapproved program. To request DMS approval, please fax this completed form to (502) 564-0223 and write "tobacco cessation program approval request" at the top of this form or on a separate cover page.

Tobacco Cessation Program Contact Person: _____

Contact Person Phone Number #: _____

Contact Person Email Address (if available): _____

Provider Signature: _____ Date: _____

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Recipient Commitment (to be completed by the recipient)

What kind of tobacco do you use? ☐ Cigarette ☐ Smokeless Tobacco ☐ Cigar ☐ Pipe

☐ I am ready to quit using tobacco and want to complete a tobacco cessation program

☐ I understand that to get medication to help me stop using tobacco, I have to participate in the tobacco cessation support program chosen for me by my provider. If my provider has written me a prescription for medication to help me stop using tobacco, I can get the first month's supply by signing this form. Before I can get my medication refilled, I must tell Medicaid that I will continue to go to the support program chosen by my provider. To do this, I can:

- Call Medicaid at 502-564-9444, or
- Write to Tobacco Cessation Program, Kentucky Medicaid, 275 East Main Street, 6C-C, Frankfort, KY 40601 or
- Send a fax to 502-564-0223

☐ I understand that I must, if asked, give an update on my progress or lack of progress in quitting tobacco.

Recipient Signature: _____

Date: _____

Provider FAX Instructions

Please fax the completed and signed form to (502) 564-0223 and give a copy of the completed and signed form to the recipient

If you have any questions, please contact the Department for Medicaid Services, Division of Medical Management at (502) 564-9444 and mention "tobacco cessation referral" as the subject of your call

PROVIDERS NOTE: A copy of this form must be on file with Kentucky Medicaid before your claim for the tobacco cessation assessment will be paid.

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Kentucky Diabetes Prevention and Control Program Evaluation Plan

Intervention Name: KDPH Diabetes Centers of Excellence (DCOE): Diabetes Disease Management Program

Target Population: Medicaid Members with more than one claim with an ICD9/ICD10 code indicating a diagnosis of diabetes.

Intervention Goal: Decrease diabetes complications, ED use and hospitalizations through improved patient self management practices and improved patient and provider compliance with ADA standards of care.

Major Components of the Intervention:

- Establish standards for DCOE program operation. (Completed)
- Train LHD staff in implementation of standardized protocol. (Completed)
- Collaborate with software designer to customize Electronic Health Record (EHR) software to document services. (Completed)
- Train LHD staff in the use of software relative to standardized protocol. (Completed)
- Provide ongoing technical support on clinical and EHR aspects of program operation. (ongoing)
- Produce periodic outcome reports (ongoing)
- Conduct regular QI site visits (ongoing)

Stakeholders:

Key Stakeholders	Main Area of Interest
Kentucky Department of Medicaid Services	Their members are the target population for the program.
Kentucky Department for Public Health: Diabetes Prevention and Control Program	Responsible for establishing program standards, overseeing software development, training LHD staff, providing ongoing technical support and monitoring program outcomes.
Local Health Department: Diabetes Centers of Excellence program staff	Responsible for providing care coordination services to Medicaid members with diabetes and communicating with Primary Care Providers.
Medicaid Primary Care Providers	Primary Care Providers are the medical home for this population. It is vital that the program support the PCP's interaction with their patient and not undermine the Dr/Patient relationship.
Medicaid Members with Diabetes	Opportunity to improve health outcomes and general quality of life. Fearful of loss of health benefits if they become "too healthy".

DCOE Program Logic Model

Diabetes Centers of Excellence Model of Influence to Improve Health Among Medicaid Patients with Diabetes and Control Costs to Medicaid Program				
INITIAL SERVICES/ACTIVITIES Provided By the Diabetes Centers of Excellence	**SERVICES/ACTIVITIES BASED ON PATIENT NEED AS DETAILED ON PLAN OF CARE**	**Expected Short Term Results (within 6 months of program participation)**	**Expected Intermediate Results (within 1 year of program participation)**	**Expected Long Term Results (measured within 2-4 years of program participation)**
• Patient outreach for enrollment • Physician outreach to encourage referrals and collaboration • Outreach to Hospital Discharge Planners and Emergency Departments to encourage referrals to program. • Assessment of patient status and barriers to care including medical home review (repeated every 3 to 6 months depending on complexity) • Assist patient in setting own self care goals • Develop custom patient care plan based on assessment • Advise PCP of patient enrollment • Request clinical data from PCP • Maintain contact with PCP regarding patient needs and progress	LHD or Community Service Referrals: • Group DSMT • Individual Medical Nutrition Counseling • Smoking Cessation Classes or Quit-line • Physical Activity groups • Support group Reminders for Professional Care: • PCP visit • Podiatrist • Eye Care • Dental Care • Endocrinology • Mental Health Referral for Other Community Services • Housing • Transportation • Literacy Ongoing monitoring of patient compliance with medications, self BGM, dietary compliance. Telephonic education on AADE7 topics for patients unable or unwilling to attend group DSMT classes.	• Participating Medicaid patients receiving group diabetes self management education. • Medicaid patients set and meet self management goals. • Improvement in self monitoring and recording of blood sugar levels • Increased medication compliance • Decrease in Modifiable Barriers to Care • PCP's provide clinical data as requested to support patient management • PCP's actively refer appropriate patients to the program	• Improved A1C control • Decreased tobacco use • Improved blood pressure control • Increased proportion of patients with 2 or more HbA1C tests annually • Increased proportion of patients having annual eye exam • Improvement in physical activity levels • Improvement in dietary choices • Improved patient self assessment • Patients report positive changes as result of program participation • PCP's report positive response to having patients participate in program.	• Reduced inpatient hospitalization and ER visits. • Lower overall medical costs directly related to diabetes

General Evaluation Purpose: The purpose of this evaluation is to: **a)** determine if services to patients are being delivered as intended, **b)** demonstrate PCP participation in program via sharing clinical data, medication lists and/or referral of appropriate patients, **c)** determine if PWD's show improvement in SBGM and medication compliance, **d)** determine if PWD's show improvement in A1C testing rate and A1C testing results, **e)** determine if PWD's show positive changes in self assessment and give positive evaluations of the program, f) determine if patients participating in the program have decreased ER, decreased hospitalizations, and lower diabetes related costs than comparable Medicaid members with diabetes not in the program. Because of the time lag required to collect and analyze data on item (f) above – only items (a) thru (e) are included in the evaluation plan.

Evaluation Focus: The evaluation will focus on 4 specific process areas to assess whether the program is functioning as planned, and 6 outcome measures (3 short term, 3 intermediate term) to determine whether anticipated changes are taking place for program participants.

Sample Population: The sample population will be all Medicaid enrolled DCOE clients participating in the program between October 1, 2010 and October 1, 2011. This represents the first full year of operation using the DiaWEB updated system.

Specific Evaluation Questions, Indicators and Data Collection Methods

Evaluation Question	Indicator	Data Collection Source
Process Measures		
Are Educators conducting assessments of patient status and barriers to care on program entry?	% of enrolled patients with a recorded assessment	DiaWEB patient management system
Is a care plan developed for each enrolled patient?	% of enrolled patients with a recorded plan of care	DiaWEB patient management system
Are PCP's contacted to provide lab data at program entry and on 6 month follow-up? Do PCP's provided needed lab results on program entry and at 6 month follow-up?	% of enrolled patients with a record showing lab request on entry % of enrolled patients with a record showing lab results provided by PCP. % of PCP's providing lab data for at least 90% of their patients.	DiaWEB patient management system

Evaluation Question	Indicator	Data Collection Source
Outcome Measures		
Does patient A1C control improve in this population?	Recorded A1C results at program entry and at 6 month and/or 1 year follow-up?	DiaWEB patient management system
What proportion of patients have 2 or more recorded A1C results within one year of program participation?	Recorded A1C results at program entry and at 6 month and/or 1 year follow-up?	DiaWEB patient management system
Do clients report improvement in medication compliance?	% of enrolled patients who report improvement in medication compliance (difference between initial self assessment and 6 month follow-up self assessment)	DiaWEB patient management system
Do clients report improvement in self blood glucose monitoring?	% of enrolled patients who report improvement in self blood glucose monitoring (difference between initial assessment and 6 month follow-up assessment)	DiaWEB patient management system
Do clients report improvement in diabetes management overall?	% of enrolled patients who report improvement in overall diabetes management (difference between initial self assessment and 6 month follow-up self assessment)	DiaWEB patient management system

Analysis Plan: DiaWEB includes a robust reporting process which will allow the generation of reports needed to provide the indicators identified above. Reports will be produced for each site and for all sites together. Both process measures and outcome measures will be included in one evaluation report for all audiences.

Report Audience: The target audience for the report includes the DCOE staff, KDPCP program staff, KDPH senior leadership staff, and Medicaid QI staff.

Report Goals: Provide target audience with information on the operation of the DCOE-Medicaid Diabetes Disease Management program. For program staff, results will inform improvements and adjustments to increase program effectiveness. For KDPCP and KDPH senior staff, results will inform future funding and program planning decisions.

Report Type: The report format will be a written document including quantitative results as well as written interpretation of the substantive significance of those results. Results will be shared internally (both oral reports and written reports) and may be shared at regional and national meetings via poster sessions or oral presentations if approved by senior KDPH leadership.